

MED Service Standards (July 2011)	Revision/Clarification
Med-Adult Intensive Resiliency Services (AIRS)	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Med-Assessment for MRO	
Med-Child And Adolescent Intensive Resiliency Services (CAIRS)	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Med-Medication Training and Support	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Med-Peer Recovery Services	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)

MED Service Standards	Page Numbers
Med-Adult Intensive Resiliency Services (AIRS)(Revised 6/8/11-Effective 7/1/11)	2
Med-Assessment for MRO	7
Med-Child And Adolescent Intensive Resiliency Services (CAIRS)(Revised 6/8/11-Effective 7/1/11)	12
Med-Medication Training and Support (Revised 6/8/11-Effective 7/1/11)	18
Med-Peer Recovery Services (Revised 6/8/11-Effective 7/1/11)	23

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-ADULT INTENSIVE RESILIENCY SERVICES (AIRS)
(Revised 6/8/11-Effective 7/1/11)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit). The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Adult Intensive Rehabilitative Services (AIRS) is a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS may be provided for consumers at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services; Have significant impairment in day-to-day personal, social and/or vocational functioning; do not require acute stabilization, including inpatient or detoxification services, and Are not at imminent risk of harm to self or others. AIRS may be provided to consumers less than eighteen (18) years of age, but not less than sixteen (16) years of age, with an approved prior authorization.

II. Service Delivery

- AIRS must be authorized by a physician or HSPP.
- Direct services must be supervised by a licensed professional.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Consumer goals must be designed to facilitate community integration, employment, and use of natural supports.
- Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.

- A weekly review and update of progress occurs and must be documented in the consumer's clinical record.
- AIRS programs must be offered a minimum of two (2) hours and up to six (6) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
- AIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
- The consumer is the focus of the service.
- Documentation must support how the service benefits the consumer, including when provided in a group setting.
- Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
- Service goals must be rehabilitative in nature.

Exclusions:

- AIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.
- Services that are purely recreational or diversionary in nature, or that do not have therapeutic or programmatic content, are not reimbursable.
- Formal educational or vocational services.
- A consumer may not receive both CAIRS and AIRS on the same day.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

In addition, services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

V. Goals and Outcomes

Goal #1

Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

- 1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

- 1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)

- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Qualifications

Services are provided through a behavioral health service provider that is enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate.

Individual Provider Qualifications:

- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VII. Billable Unit

Medicaid:

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding, except for court time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code	Title
H2012 HW HB U1	Behavioral health day treatment, per hour

Units = 1hour, provider must provide ≥ 45 minutes of service to round up.

DCS Funds:

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.
- **CFTM:** Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging,

teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-ASSESSMENT FOR MRO**

I Services Description

This service standard applies to services provided to children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Clinic Option (MCO), Medicaid Rehabilitation Option (MRO), and DCS Funding. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MCO or MRO may be billed to DCS. The DCS service model shall be used for this service standard.

This service standard includes the Initial Assessment-Clinic, Initial Assessment-Home, and Redetermination. A client should only receive a referral for one of these assessments at any given time.

Initial Assessment:

The purpose of this initial assessment is to have the following completed and summarized in a report:

- DMHA approved assessment
- Bio-psychosocial assessment and
- Diagnosis (if applicable).
- Summary of CMHC Recommended Services

DCS will refer for an Initial Assessment-Clinic to be completed and billed to Medicaid Clinic Option (MCO). This assessment should be completed with a report to DCS within 7 calendar days unless the services will require prior authorization (the child is not eligible for a preauthorized service package). If a prior authorization for services is required, the assessment should be completed and a report returned to DCS within 17 days.

If the family is not responsive within 3 days, the CMHC should contact the FCM to determine if the FCM wants to request the Initial Assessment to be completed in the home. If so, the FCM should complete a new referral for Initial Assessment-Home. In this instance, the Assessment time period of 7 calendar days would start over. (NOTE: The time period on the referral will be for 6 months and will be used to authorize DCS match payment electronically for that time period.)

If, at the time the FCM makes the initial referral, the FCM believes there are circumstances which would prevent the family from going to the clinic, DCS may choose to refer for an Initial Assessment-Home to be completed in the family's home. The Initial Assessment-Home unit would be paid by DCS funding.

Behavioral Health level of Need Redetermination

Redetermination Services are associated with the DMHA approved assessment required to determine level of need, assign an MRO service package and make changes to the Individualized Integrated Care Plan. The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services. Reassessment may occur when there is a significant event or change in consumer status.

II. Service Delivery

Initial Assessment:

1. Face-to face contact in a MCO approved setting is preferred.
 - a. CMHC will respond with a report in 7 calendar days from date of referral approval. If Prior Authorization is required, the CMHC will notify DCS and will respond with a report in 17 days.
 - b. The report will include the DMHA approved assessment, a Bio-psychosocial assessment, the child's diagnosis (if applicable), and the MRO Service Package or authorized services.

Redetermination

1. The redetermination requires face-to-face contact with the consumer and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.
2. The DMHA approved assessment tool must be completed at least every six months to determine the continued need for MRO services
3. Reassessment may occur when there is a significant event or change in consumer status. Reimbursement is only available for one assessment per six months. .
4. CMHC will inform the referring worker of the need for a redetermination referral at least 14 days prior to the need for the approved referral.

III. Target Population

Assessments and Redeterminations are billable to Medicaid for Medicaid eligible clients. In addition, services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

IV. Goals and Outcomes

Goal #1 To obtain an Initial Assessment that will result in the identification of the MRO service package if applicable.

Objective Measure: 95% of Initial Assessments will be completed within the designated time frames.

V. Qualifications

Initial Assessment:

Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:

- (A) A licensed psychologist.
- (B) A licensed independent practice school psychologist.
- (C) A licensed clinical social worker.
- (D) A licensed marital and family therapist.
- (E) A licensed mental health counselor.
- (F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
- (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

Redetermination:

Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.

VI. Billable Unit

Initial Assessment-MCO Clinic:

Initial Assessment-Clinic will be billed **per assessment** to clinic option for Medicaid eligible clients. Medicaid shall be billed when appropriate.

Medicaid Billing Code	Description
90801	Diagnostic Interview

Initial Assessment-Clinic (DCS Paid):

- Initial Assessment-Clinic will be paid **per assessment** by DCS for those clients who are not Medicaid eligible.

Initial Assessment-Home (DCS Paid):

- Initial Assessment-Home will be paid **per assessment** by DCS.

Behavioral Health Level of Need Redetermination:

Services through the Medicaid Rehabilitation Option (MRO) include Behavioral Health level of Need Redetermination. Medicaid shall be billed when appropriate. DCS funds should not be billed for this service.

Medicaid Billing Code	Description
H0031 HW	Mental health assessment, by non physician

VII. Case Record Documentation

Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children

- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-CHILD AND ADOLESCENT INTENSIVE RESILIENCY SERVICES
(CAIRS)
(Revised 6/8/11-Effective 7/1/11)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Child and Adolescent Intensive Resiliency Services (CAIRS) is a time-limited, curriculum-based, non-residential service provided to children and adolescents in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS is designed to alleviate emotional or behavioral problems with a goal of reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS may be provided for consumers at least five (5) years of age and less than eighteen (18) years of age with severe emotional disturbance who: Need structured therapeutic and rehabilitative services; Have significant impairment in day-to-day personal, social and/or vocational functioning; Do not require acute stabilization, including inpatient or detoxification services; and Are not at imminent risk of harm to self or others.

II. Service Delivery

- a. CAIRS must be authorized by a physician or HSPP.
- b. Direct services must be supervised by a licensed professional.
- c. CAIRS must be provided in close coordination with the educational program provided by the local school district.
- d. Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.

- e. Consumer goals and a transitional plan must be designed to reintegrate the consumer into the school setting.
- f. Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
- g. A weekly review and update of progress occurs and must be documented in the consumer's clinical record.
- h. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under receiving services.
- i. CAIRS programs must be offered a minimum of two (2) hours and a maximum of four (4) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
- j. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
- k. The consumer is the focus of the service.
- l. Documentation must support how the service benefits the consumer, including when provided in a group setting.
- m. CAIRS must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
- n. CAIRS goals must be rehabilitative in nature.

Exclusions:

- i. Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content are not reimbursable.
- ii. Formal educational or vocational services.
- iii. CAIRS is not reimbursable for children less than five (5) years of age.
- iv. CAIRS is not reimbursable for consumers age eighteen (18) and older, but less than twenty-one (21) years of age without an approved prior authorization.
- v. CAIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW UI) on the same day.
- vi. A consumer may not receive both CAIRS and AIRS on the same day.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not**

paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need, and must meet the MRO target population definition as listed above.

In addition, services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

V. Goals and Outcomes

Goal #1

Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

- 1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

- 1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Qualifications

Services are provided through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate. CAIRS may be provided in a facility provided by the school district.

Individual Provider Qualifications:

- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VII. Billable Unit

Medicaid:

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding, except for court

time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code	Title
H2012 HW HA U1	Behavioral health day treatment, per hour

Units = 1hour, provider must provide ≥ 45 minutes of service to round up.

DCS Funds:

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.
- **CFTM:** Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VIII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-MEDICATION TRAINING AND SUPPORT
(Revised 6/8/11-Effective 7/1/11)

I Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit). The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Individual:

Individual Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medication, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non face-to-face activities.

Group:

Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in a group setting, for the purpose of providing education and training about medications and medication side effects.

II Service Delivery

Individual:

1. Face-to face contact in an individual setting with the consumer and/or family or non professional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects.
2. When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option. When provided in residential treatment setting, Medication Training and Support may include components of medication management services.

3. Medication Training and Support may also include the following services that are not required to be provided face-to-face with the consumer:
- i. Transcribing physician or AHCP medication orders.
 - ii. Setting or filling medication boxes.
 - iii. Consulting with the attending physician or Authorized Health Care Professional (AHCP) regarding medication – related issues.
 - iv. Ensuring linkage that lab and /or other prescribed clinical orders are sent.
 - v. Ensuring that the consumer follows through and received lab work and services pursuant to other clinical orders.
 - vi. Follow up reporting of lab and clinical test results to consumer and physician.
 - c. The consumer is the focus of the service.
 - d. Documentation must support how the service benefits the consumer, including when the consumer is not present.
 - e. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
 - f. Medication Training and Support goals are rehabilitative in nature.

Group:

1. Face-to-face contact in a group setting with the consumer and/or family or non professional caregivers that includes education and training on administration of prescribed medications and side effects, and/or conducting medication groups or classes.
2. When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
3. Medication Training and Support must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
4. The consumer is the focus of the service.
5. Documentation must support how the service benefits the consumer, including when the consumer is not present.
6. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
7. Medication Training and Support goals are rehabilitative in nature.

Exclusions:

1. If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.
2. Coaching and instruction regarding consumer self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development.

3. Medication Training and Support may not be provided for professional caregivers.

III. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

V. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular and timely communication with referring worker.

Objectives

- 1) Provider is available for consultation to the family 24-7 by phone or in person.

VI. Qualifications

Medication Training and Support must be provided within the scope of practice as defined by federal and state law.

- Licensed physician
- Authorized health care professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a (2) year clinical program.

VII. Billable Unit

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. Medicaid shall be billed when appropriate.

Billing Code	Title
H0034HW	Medication Training and Support – Individual
H0034 HW HR	Medication Training and Support Family/Couple (Individual Setting), with the Consumer Present
H0034 HW HS	Medication Training and Support Family/Couple (Individual Setting), without the Consumer Present
H0034 HW U1	Medication Training and Support – Group
H0034 HW HR U1	Medication Training and Support Family/Couple (Group Setting), with the Consumer Present
H0034 HW HS U1	Medication Training and Support Family/Couple (Group Setting), without the Consumer Present

Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

- **Child and Family Team Meeting (CFTM):** The provider of this service may be requested to participate in the CFTM..The provider may bill DCS for this actual time spent in CFTM.

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-PEER RECOVERY SERVICES
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

Peer Recovery Services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

II. Service Delivery

- Peer Recovery Services must be identified in the Individualized Integrated Care Plan (IICP) and correspond to specific treatment goals.
- The consumer is the focus of Peer Recovery Services
- Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the IICP
- Peer Recovery Services are rehabilitative in nature
- Peer Recovery Services must be age appropriate for a consumer age eighteen (18) and under receiving services
- Documentation must support how the service specifically benefits the consumer
- Peer Recovery Services must be face-to-face and include the following components:
 - Assisting the consumer with developing self-care plans and other formal mentoring activities AIMed at increasing active participation in person-centered planning and delivery of individualized services
 - Assisting the consumer in the development of psychiatric advanced directives
 - Supporting day-to-day problem solving related to normalization and reintegration into the community
- Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction

III. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

- 1) Consumers age eighteen (18) and older
- 2) Peer Recovery Service may be provided to consumers ages sixteen (16) and seventeen (17) with an approved prior authorization.
- 3) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- 4) Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
- 5) All adopted children and adoptive families.

V. Goals and Objectives

Goal #1: To become socialized, recover, develop self-advocacy, develop natural supports and maintain community living skills.

VI. Qualifications

Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for CRS (Certified Recovery Specialist). Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or QBHP (Qualified Behavioral Health Professional).

VII. Billable Unit

Peer Recovery Services is included in adult packages only and is limited to 104 units for service package 3, 156 units for service packages 4, 208 units for service package 5, and 260 units for service package 5A. Prior Authorization is required for consumers requiring additional units of this service.

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding.

Billing Code	Title
H0038 HW	Self help/peer services, per 15 minutes

Exclusions:

- Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed
- Interventions targeted to groups are not billable as Peer Recovery Services
- Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services
- Peer Recovery Services are not reimbursable for children under the age of sixteen (16)
- Peer Recovery Services that occur in a group setting are not reimbursable

DCS Funding:

Child and Family Team Meeting (CFTM): MRO provider of this service may be requested to participate in the CFTM. The MRO provider may bill DCS for the actual time spent in CFTM.

Court Appearance: The MRO provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the MRO provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• 0 to 7 minutes do not bill		0.00 hour
• 8 to 22 minutes	1 fifteen minute unit	0.25 hour
• 23 to 37 minutes	2 fifteen minute units	0.50 hour
• 38 to 52 minutes	3 fifteen minute units	0.75 hour
• 53 to 60 minutes	4 fifteen minute units	1.00 hour

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Written reports no less than monthly or more frequently as prescribed by DCS. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.